Queen Creek Unified School District

Consent for Medical Treatment and Medical Information Form

Student's Name:_____

Date of Birth: _____

Student Grade: _____

Student ID: _____

I hereby give my consent for my child to receive treatment in the health office by Queen Creek Unified School District staff during the period of July 2024-May 2025. I understand medication of any kind is not to be sent with a child to school. Only an adult may bring in medication to the health office.

Health History

Has your child ever been diagnosed by a physician with any of the following conditions?

□No medical conditions	□ Skin Problems
□ADD/ADHD	□Vision Problems
□Severe Allergies	□Hearing Problems/Aids
□Asthma	□Bladder Condition
□Heart Problems	□Suppressed Immune System
□Bleeding Disorder	□Concussion History
□Epilepsy/Seizures	□Stomach/GI
□Depression	□Diabetes
□Anxiety	□Other

If you checked any of the above, please explain in detail:

_____

_____

Please list any allergies to medication, food, or insects.

_____

_____

What kind of reaction occurs with this allergy?

_____

Health screenings, including hearing and vision may be given during the school year. I understand that important medical information will be shared with school personnel as needed for the safety of each student. I have read this form and certify that I understand the content. If I do not want any of the services or screenings above, I will provide that in writing.

I authorize my child's health care provider to speak with the health office staff regarding my child's health and medication(s).

Student Name:_____ Grade:_____
Doctor's Name:_____ Phone:_____

In order for a student to receive medication during school hours:

1. Prescription medication must be prescribed by the student's physician. The healthcare provider medication form must be signed by the healthcare provider as well as the parent and presented to the school at the time medication is given to the health office.
2. Prescription medications must be in the original pharmacy container, labeled with the student's name, date, medication, dose, time to be taken at school, and length of treatment if applicable (ask the pharmacist to prepare a special container for school use).
3. Only the parent or legal guardian may bring the medication to school. Students are NOT allowed to transport medication EXCEPT an asthma inhaler, Epi-pen, and/or diabetic medications and supplies (with a current prescription for the student). A prescription label MUST BE ON the medication, AND written documentation that authorizes possession and self administration of the medication must be on file.
4. Medication will be administered in the presence of the school nurse and/or health assistant, or in their absence, by the person designated by the school principal.
5. All over-the-counter medication must be approved by the Food & Drug Administration and be kept in the original container with label and package directions. Only district approved OTC medication can be administered without a doctor's prescription. A physician's order will be required to give medications for more than 3 days in a row or 5 days per month.

Medications

Is your student currently on medication? □ Yes □ No

Will medication be given during school hours □ Yes □ No

(If medication is to be given at school, a signed consent by parents and health care provider must be completed and returned to the health office prior to giving medication.)

Medication name and dose:

_____

_____

What is medication used for?

_____

I give Queen Creek USD staff permission to administer the following medications to my child, following package directions and physician standing orders, if medication is available in the health office. I also agree with the above QCUSD medication administration policy. Choose either YES or NO for district approved medication (if available) to be given to your child:

Yes	No	Tylenol (acetaminophen)
Yes	No	Advil or Motrin (ibuprofen)
Yes	No	Anti-itch lotion (calagel, caladryl, cortisone cream)
Yes	No	Cough Drop
Yes	No	Triple antibiotic cream
Yes	No	Benadryl (diphenhydramine)

_____

Parent/Legal Guardian Name

_____

Phone Number

_____

Parent/Legal Guardian Signature

_____

Date